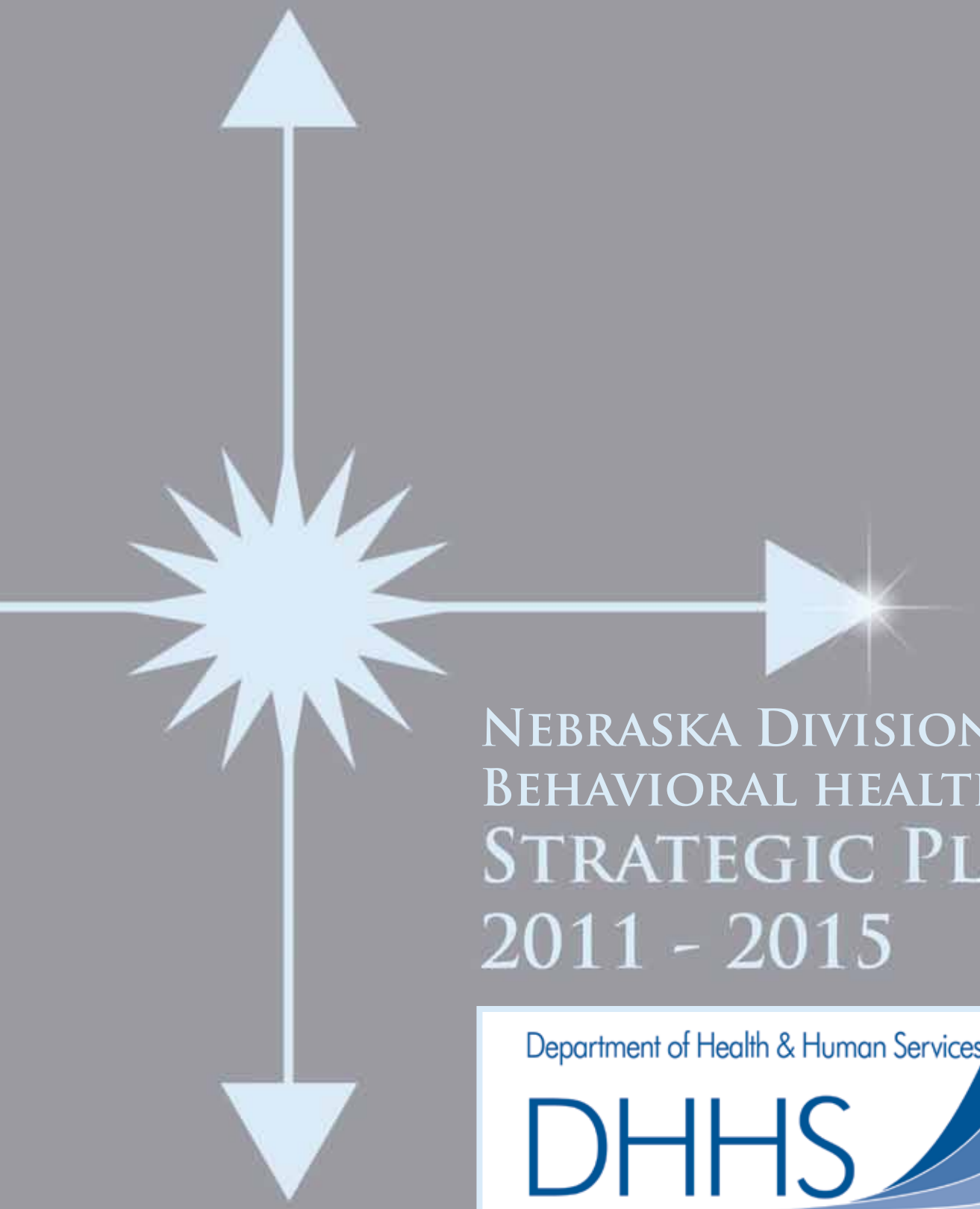
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH



NEBRASKA DIVISION OF BEHAVIORAL HEALTH STRATEGIC PLAN 2011 - 2015

Department of Health & Human Services
DHHS
NEBRASKA

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Nebraska Department of Health & Human Services
Division of Behavioral Health
301 Centennial Mall South, Lincoln, NE 68509
Ph: 402-471-3121
http://www.hhs.state.ne.us/Behavioral_Health/

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Overview

Behavioral Health in Nebraska includes three distinct service areas: Mental Health, Substance Abuse and Problem Gambling. The publicly funded system is only one part of the overall behavioral healthcare system in Nebraska. Private funding sources such as insurance companies, private businesses, and individuals themselves also influence the way behavioral health services are provided in the state. Publically funded services are administered by many different agencies including three different Divisions within the Nebraska Department of Health and Human Services: the Division of Behavioral Health; the Division of Medicaid and Long-Term Care; and the Division of Children and Family Services. In addition, other state and federal agencies (for example, State Probation through the Nebraska Supreme Court, the Nebraska Department of Correctional Services, Nebraska Department of Education Vocational Rehabilitation and the Veterans Administration) fund or support behavioral health services for specific populations. Partnerships and collaboration among these public and private systems as well as with individuals, families, agencies and communities are important components in systems of care surrounding each person.

The role of the Division of Behavioral Health in Nebraska's public behavioral health system is to provide leadership in the administration, integration and coordination of the public behavioral health system. The Division carries out this role by taking the lead, collaborating with partners and participating in the overall healthcare system as a stakeholder. This can be illustrated by envisioning three baskets – each filled with responsibilities for ensuring quality services are available in Nebraska for children, adults and families when they are needed. The first basket represents the activities and responsibilities for

which the Division of Behavioral Health takes the lead and assumes *primary responsibility*. The second basket represents behavioral health activities that require *active partnership* and shared responsibility with the Division of Behavioral Health. The third basket represents the overall behavioral and health care systems (public and private) in which the Division has an interest and stake as a partner, but may not have as active a role in carrying out activities or responsibilities. This planning document addresses the Division's role in the first two "baskets" and intends to suggest areas of focus for leaders of activities in the third basket.

National healthcare reform, mental health parity laws, economic challenges and restricted state resources provide the backdrop for this plan. This uncertainty is tempered by the Division's desire to be in the best position possible to take advantage of national changes, leading the way in care for Nebraskans while controlling cost of care. This plan is intended to be highly adaptable while we jointly work our way through these changes as a state and as a nation. The strategic framework suggested in this plan positions the Division of Behavioral Health to flexibly respond to proposed changes in the nation's healthcare system while moving forward with improvement of Nebraska's public behavioral health system.

Looking back

Nebraska's public behavioral health system began in 1870 with the creation of the Nebraska Asylum for the Insane in Lincoln. Additional institutions were added in 1885 (Norfolk) and 1887 (Hastings). It wasn't until 1946 that the Legislature made it possible to receive care on a voluntary basis at these state facilities. This institutional system was administered by a Board that evolved into the Department of Public Institutions, overseeing 13 Nebraska institutions beginning in 1962. In that same year the three state hospital names were changed to Regional Centers. Two divisions were eventually established within the Department of Public Institutions to address Alcoholism (in 1967) and Community Mental Health (1973). Regional Behavioral Health Authorities were created in 1974 to coordinate the delivery of mental health services locally. Two years later, the responsibility for coordination and delivery of substance abuse services was added to their responsibilities. The Gamblers Assistance Program was formed in 1992 and placed in the Department of Public Institutions in 1995. Soon after, in 1996, the Nebraska Partnership for Health and Human Services Act combined and reorganized several departments into the three agencies forming what is now known as the Department of Health and Human Services. Subsequent legislative actions over the last decade have accelerated the process of change in the way Nebraska's public behavioral health system functions (for a more complete history see Appendix A).

Many positive changes have been made in Nebraska's public behavioral health system as a result of legislative reform efforts in the last 10 years.

» More than 32 new community-based Behavioral Health services have been developed in collaboration with the Regional Behavioral Health Authorities since 2004.
» More than $30 million has been shifted from regional center operations to community-based services. In addition to new services, capital improvements, training, and other infrastructure needs were addressed.
» Adult behavioral health inpatient, residential, outpatient, and other services were closed at regional centers in Norfolk and Hastings.
» Services at Lincoln Regional Center were re-aligned to reflect its changing role within a community-based system of care.
» The Nebraska Network of Care website, Nebraska Family Helpline, and Family Navigators emerged as uniform statewide resources to access community-based care.
» Regional housing support services were funded and developed across the state.
» Significant expansion of gambling prevention, education and treatment services occurred as a result of new legislation.
» $14 million in new treatment services for sex offenders accompanied substantial revision to Nebraska's approach to sex offender management.
» Increased consumer involvement occurred across Nebraska.
» Consumer Specialists are employed in every region and by scores of providers.

» PREVENTION WORKS

» TREATMENT IS EFFECTIVE

» PEOPLE RECOVER

http://www.samhsa.gov

Looking ahead

The evolution of Nebraska's public behavioral health system is now intertwined with rapid changes in national health care and in our national and state economy. There are also other initiatives underway across the nation that will ultimately influence state funding and reporting requirements. For example, the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) is drafting its own strategic plan at the time of this writing, which will influence requirements for federal block grants now used to fund many of the Nebraska's behavioral health services. (For more information about SAMHSA's proposed strategic initiatives: *http://www.samhsa.gov/about/strategy.aspx*).

Trends toward leveraging technology for use in service delivery (for example, using secure internet or video in service delivery), electronic health records and service tracking, and other innovations we cannot yet envision will also influence the way we deliver care in the future.

The role of public behavioral healthcare will undoubtedly change as decisions are made about national healthcare. The Division of Behavioral Health believes healthcare discussions and

legislation ought to include behavioral health. As the health care landscape evolves, the role of Federally Qualified Health Centers in the delivery of integrated health/behavioral healthcare is anticipated to increase. The Division of Behavioral Health, in its role as the single state authority for behavioral health, hopes to partner more fully with these Centers over the next five years. Currently the Division of Behavioral Health funds services that are not covered by Medicaid (such as working with sex offenders) and services that promote recovery, for example peer support services, respite care and support groups.

The philosophies guiding how care is provided for persons with behavioral health problems are also evolving. The Division of Behavioral Health embraces the philosophical underpinnings of "person-centered and self-directed" approaches to care in recovery-oriented systems to guide its work over the next 3-5 years. Person-centered care promotes resilience and recovery for individuals and families. This philosophy serves as a litmus test against which the implementation of technology and services will be assessed. This places the person and their networks of support at the center by setting up transparent service mechanisms that value collaboration between provider and consumer. This philosophy reflects the values espoused by the members of the Nebraska Behavioral Health Oversight Commission II by emphasizing individualization, respect, hope, and personal responsibility – some of the fundamental components of Recovery (see Appendix B). Recovery-oriented systems support person-centered and self-directed approaches to care that support and promote the strengths and resilience of individuals, families, and communities as they take responsibility for their sustained health, wellness and recovery.

Today's Division of Behavioral Health

The Division of Behavioral Health is designated by Federal and State Law as the state's single authority for mental health and substance abuse issues which places responsibility with the Division to coordinate, not control, public behavioral healthcare. About $75 million (45%) of the $165 million in public funds administered through the Division are dispersed via six regional behavioral health authorities to develop and implement programs and services (commonly referred to as "regions" or "regional networks"). Gambling funds are contracted directly from the Division of Behavioral Health to a statewide preferred provider network. The Division is also responsible for administering the State's Inpatient Psychiatric Services on campuses in Lincoln and Hastings and sex offender services in Norfolk. Today's State regional centers are responsible for, in order of priority: 1) judicial confinements of individuals with mental illnesses, 2) public safety and the management of sex offenders, and 3) the treatment of involuntarily committed individuals who cannot be safely cared for in the community.

The Division of Behavioral Health carries out its responsibilities by taking the lead, serving as a partner and advocating for overall improvement of Nebraska's behavioral health system for children, adults and families. The Division is charged by statute to administer the state hospitals and publicly funded community-based behavioral health services[1]. Nebraska statutes also include specific leadership and partnership responsibilities that guide organizational priorities for the Division of Behavioral Health[2].

Leadership Responsibilities

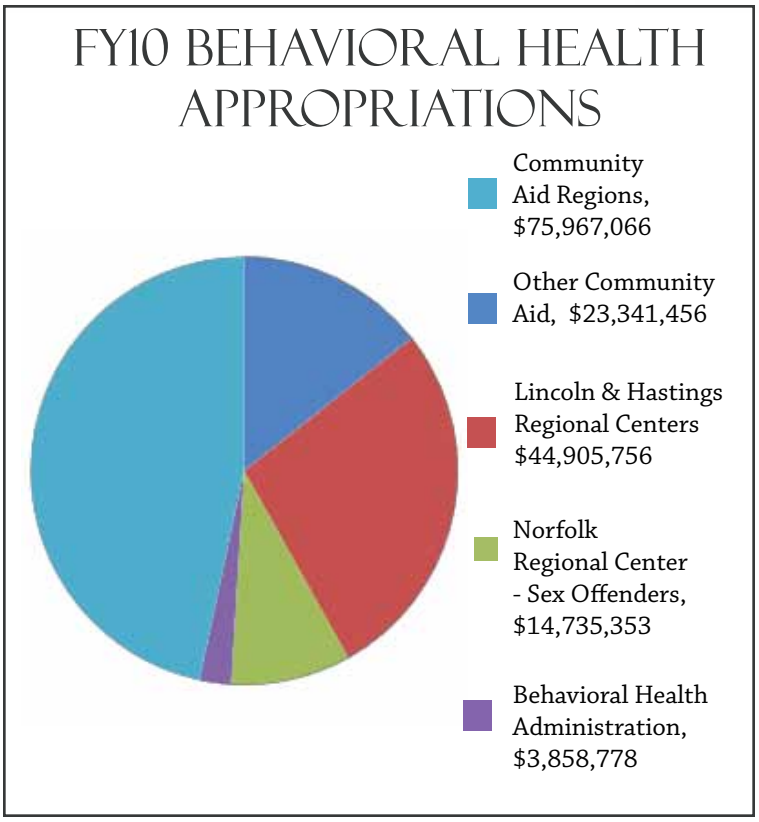
» Administration and management of the Division, Regional Centers, and other facilities and programs operated by the Division.
» Integration and coordination of the public behavioral health system.
» Comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care.
» Coordination and oversight of regional behavioral health authorities.
» Development and management of data and information systems.
» Audits of behavioral health programs and services.
» Prioritization and approval of all expenditures of funds received and administered by the division, including the establishment of rates, reimbursement methodologies and fees.
» Creation and promulgation of rules and regulations to carry out the Nebraska Behavioral Health Services Act.

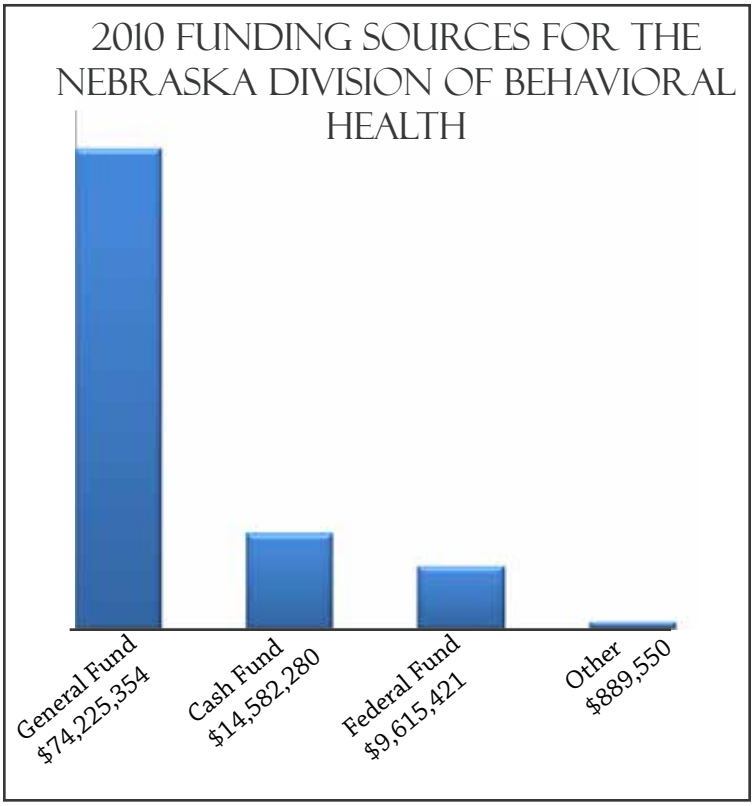
Partnership Responsibilities

» Cooperation with other divisions within the Department in the licensure and regulation of behavioral health professionals, programs, and facilities.
» Cooperation with the Department in the provision of behavioral health services under the medical assistance program.
» Promotion of activities in research and education to improve the quality of behavioral health services; recruitment and retention of behavioral health professionals; and access to behavioral health programs and services.

[1] *2007, LB296*

[2] *§71-806; Source: Laws 2004, LB 1083; Laws 2006, LB 1248; Laws 2007, LB296.*





VISION – DIVISION OF BEHAVIORAL HEALTH*

The Nebraska public behavioral health system promotes wellness, recovery, resilience and self determination in a coordinated, accessible consumer and family-driven system.

**The Vision was developed by the BHOC-II for the public behavioral health system. The full document is available at http://www.hhs.state.ne.us/Behavioral_Health/BHCommission/.*

MISSION – DIVISION OF BEHAVIORAL HEALTH

The Division of Behavioral Health provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

PUBLIC BEHAVIORAL HEALTH SYSTEM VALUES*

- HOPE
- RESPECT
- HOLISTIC
- NON-LINEAR
- PEER SUPPORT
- RESPONSIBILITY
- SELF DIRECTION
- EMPOWERMENT
- STRENGTHS-BASED
- INDIVIDUALIZED AND PERSON-CENTERED

**See Appendix B for descriptions of these values, the ten fundamental components of recovery supported by the Nebraska Behavioral Health Oversight Commission II.*

Process of Development

Nebraskans have engaged in a number of past planning initiatives related to behavioral health, both in the public and private sectors. The construction of this plan was based on review of many of these documents, including the work done by the legislatively formed Behavioral Health Oversight Commissions (LB 1083 [2004]; LB 928 [2008]), and a public/private consensus group in Omaha. A complete list of planning documents influencing this plan is available at *http://www.bhstrategicplanning.nebraska.edu*. The tasks of incorporating consumer viewpoints, reviewing prior planning documents and suggesting key areas of focus for this planning document were given to a joint strategic planning workgroup made up of representatives from the three Committees guiding the Division (Mental Health, Substance Abuse, and Problem Gambling), Behavioral Health Regions and the Division of Behavioral Health. A list of people participating in this workgroup is attached in Appendix D. The work of this group was augmented by consultation with national experts in behavioral health and opportunities for public review and comment. The process was facilitated by the University of Nebraska Public Policy Center.

Hundreds of Nebraskans participated in the development of recommendations in the planning documents and initiatives that were reviewed by the joint strategic planning workgroup. Many of the recommendations evolved from a great deal of dedication and hard work by stakeholders directly impacted by the public behavioral health system.

The Strategic Plan

This strategic plan builds on work begun by the Nebraska Legislature and Behavioral Health Oversight Commissions I and II by setting goals for the Division of Behavioral Health. These goals contribute to the development of recovery-oriented systems of care that are community-based and include prevention, intervention, clinical and recovery supports. Statutory responsibilities and results from past and current planning initiatives led to four goals and five key strategies to move the Division of Behavioral Health toward realizing the vision put forth by members of the Behavioral Health Oversight Commission II. The goals identified in this plan, in conjunction with the 2008 Children's Behavioral Health Plan, serve as a statement of intent for the Division of Behavioral Health by communicating major areas of emphasis for the plan years 2011-2015.

The strategies illustrate how the Division of Behavioral Health will approach the work needed to reach the goals. It is hoped that the strategies will also serve as guidance for everyone impacted by behavioral health systems in Nebraska. The Leadership and Partnership Initiatives outlined as part of the strategies represent more specific approaches that will be augmented in the first year with actionable steps developed by the Division of Behavioral Health, its partners, or

interest groups/coalitions (like the State Suicide Prevention Coalition). Implementation of action steps developed by the Division of Behavioral Health will be monitored by the State Mental Health, Substance Abuse and Problem Gambling Committees.

Strategies for realizing the vision, meeting the mission and achieving the Division's goals center on Accessibility, Quality, Effectiveness, Cost Efficiency and Accountability. These strategies serve as a way to structure the actions and activities funded or directed by the Division of Behavioral Health.

Each strategy is presented with three parts.

» The first relates to the role of the Division of Behavioral Health as a *leader* in the public behavioral health system.

» The second suggests key *partnerships* the Division should focus on as part of the strategy.

» The third suggests broad *outcome measures*.

More precise, specific measurements will be developed in the first year following the adoption of this plan. Appendix C contains examples of National Outcome Measures (NOMS) that the Division of Behavioral Health now regularly collects. Additional development of key "dashboard"[3] indicators will allow progress to be monitored over time as the public behavioral health system moves toward system improvement.

[3] Funding for the Consensus Panel developing the "dashboard" is through the Behavioral Health Foundation; Paid facilitators for the panel are provided by Open Minds Inc © 2010.

2011-2015 Goals:

1. The public behavioral health workforce will be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders.
2. The Division of Behavioral Health will use financing mechanisms which support innovative service content, technology and delivery structures (e.g., telehealth; in-home acute services; Peer Support Services).
3. The Division of Behavioral Health will reduce reliance on the Lincoln Regional Center for general psychiatric services.
4. An effective system to safely manage sex offenders in outpatient settings will be ready for implementation.

Strategies

The Division Will:

» Insist on Accessibility
» Demand Quality
» Require Effectiveness
» Promote Cost Efficiency
» Create Accountable Relationships

Strategy 1: Insist on Accessibility

Access to publicly funded behavioral health services is influenced in Nebraska by geography, workforce limits, culture and language barriers, organizational, technology and information barriers and cost. Accessibility is more than offering a service – it is creating an environment that allows people to make a choice to move into and out of the effective services that are close to home.

Strategy: Increase access to appropriate and effective integrated behavioral health services, particularly for vulnerable populations.

Leadership Initiatives:

1. Lead the development and implementation of standards for service access related to factors such as geography, linguistics, culture, transportation, availability of behavioral and primary healthcare services, and cost.
2. Promote public awareness of behavioral health as a vital part of overall health and well-being.
3. Develop a plan for consumer involvement at all levels.

Broad Outcome Measurement Areas

Leadership Initiative #1: Publication and implementation of standards for access for each area (mental health, substance abuse, problem gambling) and each service.

Leadership Initiative #2: The Division of Behavioral Health will work with the Division of Public Health to identify measures to assess the impact of targeted promotional activities on perception of Nebraskans.

Leadership Initiative #3: The Division of Behavioral Health Office of Consumer Affairs will lead a process that results in a plan with wide acceptance from consumers and families.

Partnership Initiatives:

1. Partner with Regional Behavioral Health Authorities to assure that a full and comprehensive needs assessment is complete as a baseline for accountability.
2. Partner with the criminal and juvenile justice system to ensure prompt access to well designed, supported and effective behavioral health services for individuals and families.
3. Partner with stakeholders and the Office of Consumer Affairs to ensure access to appropriate housing, education and employment for persons with multiple needs.
4. Partner with the Division of Public Health and Federally Qualified Health Centers to ensure behavioral health populations have access to primary health care services.
5. Create recovery-oriented systems of care that include recovery supports (such as transportation and peer supports) that can ease barriers to accessing care.
6. Partner with Probation, Parole and Victim Advocate Organizations to explore and test safe community treatment options for sex offenders.

Measuring the success of strategies aimed at increasing accessibility to behavioral healthcare starts with identifying how accessible or inaccessible care is. Current methods and new tools for computing and reporting measures of consumer satisfaction with accessibility, access/penetration measurements and service utilization data will be reviewed to yield even more precise measurements of access.

Strategy 2: Demand Quality

Quality behavioral healthcare requires workforce skills and recovery competencies that ensure services delivered are effective. Quality is continually monitored so improvements can be swiftly incorporated by providers and administrators in partnership with consumers.

Strategy: Improve the quality of public behavioral health services for children and adults.

Leadership Initiatives:

1. Implement a quality improvement system measuring outcomes and system performance based on nationally recognized behavioral health measures.
2. Convene a team to review the impact of a changing health care environment on the public specialty behavioral health system with an eye toward integration, innovation and improvement.

Broad Outcome Measurement Areas

Leadership Initiative #1: Demonstration of the system's ability to monitor and evaluate quality on an ongoing basis via transparent reporting.

Leadership Initiative #2: Development of recommendations by the proposed team.

Partnership Initiatives:

1. Partner with state agencies, Nebraska higher education, and other stakeholders to improve data collection, data analysis, and evaluation capacity.
2. Partner with people who have lived experience via the Office of Consumer Affairs to identify measurable, meaningful quality indicators.
3. Partner with the Divisions of Medicaid and Long-Term Care and Public Health to improve overall health of behavioral health service consumers.
4. Partner with stakeholders to identify the staffing, technology infrastructure and analytical skill sets needed within the Division of Behavioral Health to carry out quality monitoring functions.
5. Partner with the Behavioral Health Education Center of Nebraska (BEHCN) to develop and implement a dynamic workforce development plan for all levels of behavioral health professionals including Peer Support Professionals.

Additional quality measures may include behavioral health measures from the individual state system performance and agency scorecards of the Commonwealth Fund and the National Center for Quality Assurance's HEDIS measures for clinical care and recovery dimensions. Quality measures will include consumers input and information or recovery supports.

Strategy 3: Require Effectiveness

Effectiveness in behavioral healthcare includes implementation of practices that show the most evidence for achieving positive outcomes. Effectiveness requires sound data infrastructure collection and monitoring practices.

Strategy: Improve outcomes for children and adults through the use of effective services.

Leadership Initiatives:

1. Lead a continuous quality improvement process for services funded by the Division of Behavioral Health, focusing on clinical supervision, peer support, co-occurring mental health and addiction services, gender, trauma and cultural competency.
2. Develop standards for services based on results of the quality improvement focus and on other empirically supported approaches.
3. Implement processes to ensure fidelity to empirically supported* approaches.
4. Identify and monitor promising and innovative practices.
5. Increase the capacity of the system to use empirically supported services and practices that work for Nebraskans.
6. Eliminate Division of Behavioral Health funding for activities that do not demonstrate effectiveness.
7. Determine appropriate number of general psychiatric beds for the Lincoln Regional Center.
8. Develop strategies to reduce reliance on the the Lincoln Regional Center for general psychiatric services.
9. Develop DBH data capacity.

Broad Outcome Measurement Areas

Leadership Initiative #1: Implementation of quality improvement approaches.

Leadership Initiative #2: Publication of standards for each Division of Behavioral Health funded behavioral health service

Leadership Initiative #3: Publication and implementation of fidelity standards** and protocols for monitoring that are agreed upon by consumers, providers and payors.

Leadership Initiative #4: Implementation of a process for identifying promising practices in Nebraska.

Leadership Initiative #5: Utilization of financing and tracking mechanisms in place to gauge number, type and outcomes associated with practices in mental health, substance abuse and problem gambling.

Leadership Initiative #6: Adoption of a protocol for assessing effectiveness.

Leadership Initiative #7: Adoption of a service array in communities to support the appropriate number of general psychiatric beds at the Lincoln Regional Center.

Leadership Initiative #8: Implementation of strategies and community services to support appropriate utilization of the Lincoln Regional Center.

A number of National Outcome Measures are tied to measuring effectiveness (See Appendix C). For example, effective services keep people out of the criminal justice system, in stable housing and in school or work. The Division of Behavioral Health is interested in measuring the effectiveness of public safety driven services like court ordered and sex offender care.

Strategy 3: Require Effectiveness (con't)

Partnership Initiatives:

1. Partner with public health entities and local partners to implement effective behavioral health prevention and early intervention plans using the strategic prevention framework.
2. Partner with national and state experts to ensure consumers, their networks of support, providers and administrators have access to the latest knowledge on empirically supported* approaches the latest knowledge on empirically supported and promising practices.
3. Partner with Regional Behavioral Health Authorities to identify and implement continuous quality improvement approaches.
4. Partner with Regional Behavioral Health Authorities, providers and people with lived experience through the Office of Consumer Affairs to identify and document promising and innovative practices that are linked to improved outcomes.
5. Partner with the Division of Public Health and Division of Medicaid and Long-Term Care to further the principles of recovery oriented systems of care.
6. Partner with Consumers, Families, Regions, and providers to identify system wide actions to reduce reliance on Regional Center general psychiatric services.

*What is the difference between a practice that is *evidence-based* and one that is *empirically-supported*?
Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation are "Evidence-based." The phrase "empirically-based" is used in this plan to encompass practices that have an evolving body of research or data to support their use, but not enough rigorous scientific testing to make it evidence-based. This stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

**What is *Fidelity*?
Fidelity of implementation occurs when implementers of a research-based program or intervention (e.g., teachers, clinicians, counselors) closely follow or adhere to the protocols and techniques that are defined as part of the intervention. For example, for a school-based prevention curriculum, fidelity could involve using the program for the proper grade levels and age groups, following the developer's recommendations for the number of sessions per week, sequencing multiple program components correctly, and conducting assessments and evaluations using the recommended or provided tools.

Retrieved 10/31/2010 from: http://www.nrepp.samhsa.gov/AboutGlossary.aspx#Evidence-based

Strategy 4: Promote Cost Efficiency

Future resource availability is uncertain and changing. Balancing available funding, partnerships and other network resources with flexibility and efficiency will promote cost-efficient practices in behavioral healthcare.

Strategy: Develop flexible and balanced funding to support an efficient and accountable person-centered, recovery oriented system of services.

Leadership Initiatives:

1. Develop and implement performance based and recovery oriented contracting.
2. Build the capacity to conduct cost-benefit and cost-effectiveness studies within the quality improvement systems of the Division of Behavioral Health.

Broad Outcome Measurement Areas

Leadership Initiative #1: Published cost benefit information for possible contracting options.

Leadership Initiative #2: Implementation of data infrastructure within the Division of Behavioral Health that facilitates efficient, timely collection and reporting of information (by persons served and by services provided).

Partnership Initiatives:

1. Partner with state agencies to achieve a balanced level of state and federal funding for behavioral health care.
2. Partner with stakeholders to ensure the behavioral health needs of Nebraskans are addressed in a community based and changing healthcare environment.
3. Partner with the Division of Public Health to produce a single, integrated behavioral health professional credential that recognizes professional specialties in Substance Abuse, Mental Health, Problem Gambling and treatment of complex problems like sex offender care.

Measurements to gauge improvement in cost benefit and improvement in cost effectiveness will be identified and regularly tracked by service and by person.

Strategy 5: Create Accountable Relationships

Accountability in relationships is essential to development of recovery-oriented systems of care. Accountability maximizes the full potential of our limited resources and in working to gain lifelong partners to support the recovery community. The Division of Behavioral Health is committed to creating a culture of accountability and collaboration in all of its relationships.

Strategy: Encourage transparent, accountable relationships with and among system stakeholders.

Leadership Initiatives:

1. Develop measures of accountability in the Division of Behavioral Health relationships with other state agencies and stakeholders.
2. Develop measures of accountability within the Division of Behavioral Health.

Broad Outcome Measurement Areas

Leadership Initiative #1: Publication of annual performance by Division of Behavioral Health using developed measures of accountability.

Leadership Initiative #2: Dissemination of Division of Behavioral Health internal measures of accountability.

Partnership Initiatives:

1. Partner with stakeholders outside of the Department of Health and Human Services to support adults, youth and children who have needs related to mental health, substance abuse and/or problem gambling.
2. Partner with people who have lived experience with mental health, substance abuse and/or problem gambling via the Division of Behavioral Health Office of Consumer Affairs and Regional Behavioral Health Authorities to use all available tools, strengths and resources to help people achieve the highest quality of life.

System-level measures include things like improvement in social networks, resilience and support capacity. It also includes improvement in variables like trust and positive community regard.

Although this strategic plan focuses on the roles of the Division of Behavioral Health as a leader and key partner in the public behavioral health system, the importance of behavioral health access, quality, effectiveness, cost efficiency and accountability extends beyond the public system. The third "basket" represents the larger health care system and the role of the Division of Behavioral Health as a stakeholder in that system. The Division of Behavioral Health has a particular interest, or stake, in ensuring that individuals with behavioral health needs have access to appropriate services as healthcare changes. The "Stakeholder Basket" holds ideas and issues that may encourage other entities and individuals in their work within behavioral health.

STAKEHOLDER

Together, we can all work toward a healthier Nebraska by:

» Developing a health care system where behavioral health needs are considered as vital and important as physical health needs.

» Encouraging a culture of social responsibility among neighbors and within communities that normalizes recovery and decreases discrimination of people with behavioral health problems.

» Assisting communities and networks of support to create accountable relationships that do not look to government to replace familial or personally chosen supports.

» Increasing the number and availability of self help and support groups.

» Welcoming the participation of persons in recovery in the workforce.

Afterword

Behavioral health means many things to many people. What most people agree upon, though, is that behavioral health is essential to the health of every individual.

The Division of Behavioral Health reviewed thousands of comments, documents, ideas, and concerns from across Nebraska and the nation concerning behavioral health, most from those who have interest in the topic because of painful personal experiences. In the end we propose this plan to encourage sound behavioral health practices for all, to provide treatment when necessary, and to celebrate recovery.

I wish to thank the many individuals who have made this plan possible, and whose lives have demonstrated the reality that recovery is real. The Division of Behavioral Health dedicates itself to implementing the ideas and goals of this plan with our partners to improve the possibility of recovery for all Nebraskans.

Scot L. Adams, Ph.D.
Director, Division of Behavioral Health
December, 2010

Glossary

Behavioral health – This includes Mental Health, Substance Abuse, and Problem Gambling.

Community-based care – This refers to care provided in the community, not at a State Regional Center (LB1083-2004).

Consumer driven – Refers to mental health treatment and related services in which consumers are the primary decision-makers about the care offered and received. Consumer-driven care reflects both the individual and collective consumer voice in all aspects of mental health service delivery including choice of supports, program planning, service implementation, evaluation and research.

Co-occurring Disorders (COD) – refers to co-occurring substance-related and mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders.

Empirically supported practice – Services and supports that have been shown by research to be effective; sometimes called evidenced based or evidence informed practices.

Integrated health care – This means that if a person is participating in a health home, that person's health care, from primary care doctor to dentist to behavioral health professional, all share the same information and coordinate treatment based on that information.

Person-centered care - Services and supports are designed around the needs, preferences and strengths of individuals.

Recovery-oriented System of Care (ROSC) – A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life.

Self-directed approach – Approach to care that encourages and supports individuals in exercising the greatest level of choice possible over their service and support options and taking responsibility for their recovery.

Wellness – Wellness is a concept that embraces a way of living that helps all people enjoy a more satisfying, productive, and happy life. It is, by definition, a conscious, deliberate process that requires a person to become aware of and make choices for a more satisfying lifestyle. A wellness lifestyle is balanced; it includes cultivating healthy habits that contribute to a better quality of life.

APPENDIX A: HISTORY OF NEBRASKA'S BEHAVIORAL HEALTH SERVICES

A History of Nebraska's Behavioral Health System

1867: Nebraska achieved statehood and thus began the creation of state provided provisions.

1870: The Legislature created the Nebraska Asylum for the Insane in Lincoln.

1885: The Legislature created the Insane Asylum in Norfolk.

1887: The Legislature created the Asylum for the Incurably Insane at Ingleside (Hastings).

1920:

» A constitutional amendment changed the name of the Board of Commissioners of State Institutions to the Board of Control.
» The names of the three Insane Asylums were changed to the Lincoln State Hospital, Hastings State Hospital and Norfolk State Hospital.

1946:

» The Legislature changed the name of the Boards of Insanity to Boards of Mental Health.
» The Legislature passed a Voluntary Admissions Law, allowing persons needing psychiatric treatment to voluntarily enter a state hospital without being committed.

1947: The Legislature created the Nebraska Psychiatric Institute as an alternative to a fourth state hospital.

1961: The name of the Board of Control was changed to the Department of Public Institutions. This department was given control of 13 Nebraska institutions. The department began operating on Jan. 1, 1962.

1962: The names of the three state hospitals were changed to Lincoln Regional Center, Hastings Regional Center and Norfolk Regional Center.

1967: The Legislature created the Division of Alcoholism in the Department of Public Institutions. The governor appointed the director of the division.

1973: The director of the Department of Public Institutions established the Community Mental Health Division.

1974: Regions are established to develop and coordinate mental health services.

1975: The Nebraska Psychiatric Institute was transferred from dual operation by the University of Nebraska Medical Center and the Department of Public Institutions to sole operation by UNMC.

1976: Regions are charged with developing and coordinating substance abuse services.

1988: No longer possible to hold a person with a mental illness in a jail if no crime had been committed.

1991: First Consumer Liaison is hired.

1992: The Gambler's Assistance Program (GAP) was formed as part of the Nebraska Lottery Act, administered by the Department of Revenue. The Nebraska Advisory Commission on Compulsive Gambling was created.

1994: The Division of Behavioral Health hosts its first Statewide Consumer Conference.

1995: Administration of the Gambler's Assistance Program was transferred from the Department of Revenue to the Division on Alcoholism, Drug Abuse and Addiction Services in the Department of Public Institutions.

1996: The Nebraska Partnership for Health and Human Services Act combined the Departments of Health, Aging, Social Services, and Public Institutions and the Office of Juvenile Services and reorganized them into three Departments: HHS Finance and Support, HHS Regulation and Licensure, and Health and Human Services. These three state agencies formed the Nebraska Health and Human Services System.

1997: The Health and Human Services System was implemented on January 1. The document "Recovery: A Guiding Vision" is created.

1998: A Legislative Task Force examined delivery and financing of services for adults with mental illnesses or addictions (LB 1354).

2001:

» $8M was appropriated annually in new funding for community-based behavioral health services. (LB 692)

» Changed disbursement of documentary stamp tax funds to the Affordable Housing Trust Fund and Homeless Shelter Assistance Trust Fund; transferred administration of Homeless Shelter Assistance Trust Fund from the Department of Economic Development to the Health and Human Services System.

» $1.3 million appropriated to the HHS System for additional sex offender beds at LRC.

» $50,000 from Charitable Gaming Operations Fund transferred to Compulsive Gamblers Assistance Fund by November 1st of each year, unless the fund contains less than $50,000.

» Nebraska Health Care Cash Funds distributed in FY 01/02 and FY 02/03 (LB 692):
  - $7.5 M to increase rates paid to providers of MH/SA services.
  - $6.5 M for community-based MH/SA services including intermediate-level residential care.
  - $1.5M for maintenance and treatment of MH patients under emergency protective custody.

2003: Legislation created a 'road map' to reform behavioral health services (LB 724).

APPENDIX A: HISTORY OF NEBRASKA'S BEHAVIORAL HEALTH SERVICES

2004:

» The Nebraska Behavioral Health Reform Act was implemented (LB 1083).
» Closed adult acute hospital services at the Hastings Regional Center (March).
» Consumer Liaison Introduces Vision of National Memorial to the National Consumer Survivor Mental Health Administrators.

2005:

» Stopped adult mental health admissions to Norfolk Regional Center (November).
» Appropriated $500,000 from NE Health Care Cash Fund for FY 05-06 for compulsive gamblers assistance programs.
» Transfer from Affordable Housing Trust Fund to the BH Services Fund, to be used for housing-related assistance for very low-income adults with serious mental illness (LB40).
» Allows disclosure of being on Sex Offender Registration Act to governmental agencies conducting confidential checks for employment, volunteer, licensure or certification purposes.
» Changed training requirements related to alcohol and drug counselor training supervisors, changes provisions on the Compulsive Gamblers Assistance Fund; requires the Division of BH to maintain data/information system for all people receiving state-funded BH services; changes members for State BH Council, Advisory Committee on Substance Abuse and State Advisory Committee on Problem Gambling/Addiction Services.

2006:

» Moved adolescent acute hospital services from Lincoln Regional Center to Hastings Regional Center (January).
» Standards/procedures for rehabilitation of clandestine drug lab sites.
» Civil commitment and community supervision for sex offenders, changed Sex Offender Registration Act, adopted the Sexual Predator Residency Restriction Act, established a work group to study sex offender treatment and management services (LB 1199).
» Converted mission of Norfolk Regional Center to a state sex offender facility and began joint program with Lincoln Regional Center (July).

2007:

» The Division of Behavioral Health funds Consumer Specialists in all Regions.
» Closed adolescent acute hospital services at Hastings Regional Center (January).
» Closed adult residential services at Hastings Regional Center (April).
» Created a new licensure category of independent mental health practice.
» Reorganized the Health and Human Services System into a single state agency known as the Department of Health and Human Services (LB 296).
» Required DHHS to develop policies/rules and regulations on transfer and discharge of sex offenders treated in DHHS program.
» Created the Children's BH Task Force and required submission of a children's behavioral health plan (LB 542).

2008:

» Changed membership on Children's BH Task Force.

» Revised the definition of consultation to include consultation between a licensed MH practitioner and an independent MH practitioner. Clarified when someone can use the titles of independent clinical worker, independent professional counselor and independent marriage and family therapist.
» Expanded duties of State Committee on Problem Gambling and changed name from former State Advisory Committee on Problem Gambling and Addiction Services.
» Deficit appropriations included:
  • $900,000 state and $1,350,000 federal funds for 1.5% rate increase for providers.
  • Unexpended behavioral health aid funds distributed for one-time payments to regions for development of community BH services.
  • Regional funds to be appropriated to regions for development of community BH services.
» Expanded the authority of the Ombudsman to all mental health institutions operated by DHHS, all regions and all community-based BH service providers that contract with the Regions.

2009:

» Amended Sex Offender Registration Act to bring Nebraska into compliance with federal guidelines so that length of registration is based solely on the convicted offense; expanded list of registry offenses; expanded registration information that is collected.
» Changed terminology relating to problem gambling services, eliminating 'addiction services' and replacing 'compulsive' with 'problem' gambling.
» Required establishment of a children and family support hotline; a family navigator program to respond to children's BH needs; post-adoption and post-guardianship care management services for adoptive families/guardians of former state wards; submission of a state Medicaid plan waiver to CMS for community-based secure residential and sub-acute BH services whether committed by a MH Board or not; provided DHHS $500,000 for FY 09-10 and $1 M for FY 10-11 for children's BH services; created a legislative Children's BH Oversight Committee; established the Behavioral Health Education Center (BHECN) to recruit and train more psychiatry residents (LB 603).
» Merged financial operations at Regional Center (July).
» Omaha, NE hosts the national Alternatives Conference.

2010:

» The Office of Consumer Affairs hosts its first Peer Support Training and forms a Facilitator's Circle.
» Completed Substance Abuse Block Grant technical review resulting in Technology Transfer recognition.

APPENDIX A: HISTORY OF NEBRASKA'S BEHAVIORAL HEALTH SERVICES

BEHAVIORAL HEALTH SERVICES: RECENT DEVELOPMENT & EXPANSION BY FISCAL YEAR

FY96 - FY04 SERVICES

Day Treatment	Halfway House-Men	Home-Based
Partial Care in 96/97	Halfway House-Women	Respite Care
Day Rehabilitation	Crisis Assessment (LADC)	Therapeutic Consultation
Outpatient Therapy (Ind/Fm/Grp)	Crsis Assessment (CADAC)	Therapeutic Community
OutPatient Therapy (Ind)	Emerg Shelter-Psych Respite	Partial Care
Medication Management	Emerg Shelter-Social Detox	Outpatient Therapy - (Ind/ Fam/Grp)
Med Maintenance-Methadone	Emerg Comm Support	Med Management
Psychological Testing	Emerg Protective Custody Crisis	Intensive Outpatient
Voc Support	Civil Protective Custody	Youth Assessment
Day Support	Community Support-Level 2	Community Support
Intermediate Residential Treatment	Assertive Community Treatment	
Psych Res Rehab	Prevention	
Dual Disorder Residential Treatment	Professional Partner	
Short Term Residential Treatment		
Short Term Residential Treatment Native Americans		
Therapeutic Comm		

FY05 NEW SERVICES

Inpatient Acute
Inpatient Subacute
Emergency - Crisis Response Teams
Emergency - Urgent Crisis Treatment
Emergency - Urgent Outpatient
Emergency - Urgent Med Management
Emergency - Stabilization/Treatment (Voluntary)

FY06 - FY08 NEW SERVICES

FY06 Services	*FY07 Services*	*FY08 Services*
Post Commit Days	Intensive Case Management	Secure Residential Treatment
Urgent Assessment	Supported Employment	
Nurse-Day Rehab	Short Term Residential LMHP/RN	
Telemedicine		
Adolescent Intensive Outpatient		

FY09 - FY10 NEW SERVICES

FY09 Services	*FY10 Services*
Voucher Program	Housing-Related Assistance
Supported Living	Services Evaluation/ Med Support
Bi-Lingual/Bi-Cultural Outpatient	Hospital Diversion
Youth Transition	Recovery Support
Comm Support - Special Populations	BH Integation with Primary care
Peer Support	Homeless Support
Geriatric Therapeutic Consultation	Underserved Populations
Network of Care	Family Support - Substance Abuse
	Youth Special Services

Notes to Appendix A:

Appendix A includes references to a number of significant dates in the development of the Nebraska Behavioral Health System. It is not all-inclusive.

In addition to services listed, DBH works with Nursing Facilities and Assisted Living Facilities to provide consultation and supplemental services when appropriate. (8/21/2009)

APPENDIX B: BEHAVIORAL HEALTH OVERSIGHT COMMISSION II VISION / VALUES

Behavioral Health Oversight Commission II Vision/Values

The Nebraska Department of Health and Human Services, Division of Behavioral Health Strategic Plan is indebted to and begins with a vision and core values/guiding principles crafted by the Behavioral Health Oversight Commission II – a group established by the Nebraska Legislature (LB928 – 2008). The full report is available at: *http://www.hhs.state.ne.us/Behavioral_Health/BHCommission/BHOC-FinalReport-06-25-09.pdf* .

Vision: Share a cooperative and common vision among DHHS divisions regarding recovery, best practice, access to care, and funding.

The Public Behavioral Health System in Nebraska will…

- Promote wellness, recovery, resilience, and self determination in a consumer/family driven system.
- Focus on positive outcomes and continuous quality improvement for the Division, Behavioral Health Authorities, providers and recipients of services.
- Provide inclusive, transparent planning through genuine partnership with diverse stakeholders, including meaningful participation by consumers.
- Focus on prevention/early intervention.
- Share a cooperative and common vision among DHHS divisions regarding recovery, best practice, access to care, and funding.
- Encourage public/private partnerships.
- Maximize available revenue sources, including Federal grants and maximization and capture of Federal Medicaid match dollars, and new revenue sources will be reinvested in the behavioral health system.

Values & Principles

The following core values and guiding principles resulted from the work in June 2009 of Nebraska's Behavioral Health Oversight Commission. They are meant to guide work within the public behavioral health system but are also applicable to Nebraska's private mental health, substance abuse and problem gambling services.

Self Direction:
Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.

Individualized and Person Centered:
There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment:
Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny

and influences the organizational and societal structures in his or her life.

Holistic:
Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear:
Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths Based:
Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support:
Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect:
Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility:
Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope:
Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation (U.S. Department of Health and Human Services, 2005).

APPENDIX C: NATIONAL OUTCOME MEASURES (NOM)

National Outcome Measures (Substance Abuse and Mental Health Services Administration)

NOM-MH: Mental Health
NOM-PR: Prevention
NOM-SA: Substance Abuse

Accessibility
National Outcome Measure for Mental Health (NOM-MH) and Prevention (NOM-PR) (Access/Capacity): Number of persons served by age, race, ethnicity, gender.

Substance Abuse

NOM – SA (Substance Abuse & Access/Capacity): Unduplicated count of persons served; penetration rate – numbers served compared to those in need.

Quality

NOM – MH (Perception of Care): Clients reporting positively about outcomes.

NOM – MH (Social Connectedness): Clients reporting positively about social connectedness.

NOM – PR (Social Connectedness): Family communication around drug use.

Cost Efficiency

NOM – PR (Cost Effectiveness): Services provided within cost bands.

Effectiveness
NOM – SA (Reduced Morbidity): Reduction in/no change in frequency of use at date of last service compared to first service.

NOM – PR (Reduced Morbidity): 30 day substance use (non-use/reduction in use.

NOM – PR (Reduced Morbidity): Perceived risk/harm of use.

NOM – PR (Reduced Morbidity): Age of first use.

NOM – PR (Reduced Morbidity): Perception of disapproval/attitude.

NOM – SA (Crime and Criminal Justice): Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service.

NOM – PR (Crime and Criminal Justice):Alcohol related car crashes and drug related crime.

NOM – MH (Retention): Decrease in rate of readmission to State psychiatric hospitals within 30 and 180 days.

NOM – SA (Retention): Length of stay from date of first service to date of last service and unduplicated count of persons served.

NOM – PR (Retention): Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message.

NOM – MH (Stability in Housing): Profile of client's change in living situation (including homeless status).

NOM – SA (Stability in Housing): Increase in/no change in number of clients in stable housing situation from date of first service to date of last services.

NOM – MH (Employment/Education): Profile of adult clients by employment status and of children by increased school attendance.

NOM – SA (Employment/Education): Increase/no change in number of employed or in school at date of last service compared to first service.

NOM – PR (Employment/Education): Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment.

Retrieved October 27, 2010 from: http://www.nationaloutcomemeasures.samhsa.gov/PDF/NOMS/revised_grid_4_1_08.pdf

APPENDIX D: ACKNOWLEDGEMENTS

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Joint Strategic Planning Work Group
Members of this group were chosen by the body they represent. The joint strategic planning group was charged with the following:

» Recommend key areas that require additional stakeholder involvement/input prior to inclusion in a strategic plan.
» Recommend and prioritize methods for obtaining additional stakeholder involvement in the planning process.
» Review documents and stakeholder input.
» Serve as a liaison for their constituencies in the planning process.

Joint Strategic Planning Work Group Members

State Committee on Problem Gambling
Jerry Bauerkemper
John Bekins

State Advisory Committee on Mental Health Services (§ 71-814)
Kasey Moyer
Sharon Dalrymple

State Advisory Committee on Substance Abuse Services (§ 71-815)
Rand Wiese
Corey Brockway

Regional Behavioral Health Authorities
C.J. Johnson

Division of Behavioral Health
Vicki Maca
Sheri Dawson

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